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Opioids: Trouble in Paradise

It has never been a more difficult time for a physician to treat a worker with chronic opioids for non-cancer pain. In the 1980s, Oregon physicians were at risk of disciplinary action if deemed to be over-utilizing narcotics for non-cancer pain.

In the 1990s, this position changed drastically. Physicians were expected to treat non-cancer pain with narcotic medications. We were reassured that long-acting opioids represented a safe breakthrough in the management of chronic non-cancer pain. Unfortunately, this was not accompanied by the appropriate regulation or safeguards and scientifically based literature. Now, physicians are more likely to be disciplined for not appropriately treating non-cancer pain.

What many anticipated would be a safe and effective means of managing non-cancer pain has resulted in a nationwide public health epidemic, as shown in CDC: Grand Rounds, February 17, 2011:¹

- Deaths from prescription medication in 2007: > 27,000/year
- A death from prescription medication occurs every 19 minutes
- Opioid medication utilization in the United States:
 - 1997: 96 mg/person
 - 2007: 698 mg/person
- Doses above 100 mg/day Morphine Equivalent Dose [MED] are associated with significant increased risk of death.

More specifically, data in Oregon shows:²

- Retail sales of oxycodone:
 - 1997: Oxycodone—1800 g/100,000 population
 - 2006: Oxycodone—16,600 g/100,000 population
- Deaths from methadone overdose:
 - 1999: 0.2/100,000 population
 - 2008: 3.6/100,000 population
- Deaths in the age group of 25-54 years:
 - Prescription medication overdose deaths now exceed motor vehicle deaths
 - Oregon ranks fifth in prescription abuse in the United States, and first in the age group of 18-25 years.³

¹ CDC: Grand Rounds; Prescription Drug Overdose: An American Epidemic; Feb. 17, 2011.

² Office of Disease Prevention and Epidemiology, Oregon Public Health Division.

³ Oregonian, Oregon Ranks Fifth in Prescription Painkiller Abuse in the United States, Berstein, M., 11/22/10.

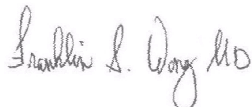
We are now faced with a rapidly growing number of studies, which document the lack of functional improvement and increased risk of harm to patients and workers on long-acting opioids for non-cancer pain.⁴

Caremark Comp is addressing this dilemma with the development of a new Treatment Standard for Chronic Opioid Therapy (COT), which will be useful for physicians in maintaining the delicate balance between treatment of non-cancer pain and over-treatment/abuse. It will be a standard based on the most current literature available and the recognition of the significant morbidity/mortality that is associated with over-treatment.

This standard is currently being developed and reviewed, and upon completion, it will be distributed to you. It is our goal that this standard will provide a meaningful/functional resource in treating non-cancer pain safely and with appropriate monitoring. Enclosed is, "Cautious Responsible Opioid Prescribing," published by the Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain, which clarifies the myths and facts about COT.⁵

Thus, there really is no "paradise" in using chronic opioids for non-cancer pain. Watch for the standard and its date for implementation. If you have any questions, please contact me at MHN, (503) 413-5800.

Sincerely,



Franklin S. Wong, M.D.
Medical Director

Enclosure

⁴ Chou R., Clark E., Helfand M., Comparative Efficacy and Safety of Long-Acting Oral Opioids for Chronic Non-Cancer Pain: A Systematic Review. *J. Pain Symptom Management*, 2003; 26:1026-1048.

⁵ Washington State Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain; ADC Medical Directors Group, 2010 Update.

Cautious Responsible Opioid Prescribing

Despite low-quality evidence supporting practice change,¹⁻⁶ use of chronic opioid therapy (COT) for chronic non-cancer pain increased dramatically over the past two decades³⁴⁻³⁶. Concurrently, opioid diversion, prescription opioid addiction/misuse, and fatal overdose involving prescription opioids increased markedly.^{20,37} To reduce these and other problems related to COT, it is essential that clinicians adhere to cautious, responsible practices when considering opioids for chronic pain.

Myths and facts about chronic opioid therapy (COT)

Myth COT for chronic pain is supported by strong evidence.

FACT Evidence of long-term efficacy for chronic non-cancer pain (≥ 16 weeks) is limited,^{1,2,3} and of low quality.^{4,5} Opioids are effective for short-term pain management. But, for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.⁶

Myth Physical dependence only happens with high doses over long periods of time.

FACT With daily opioid use, physical dependence and tolerance can develop in days or weeks.^{7,8}

Myth Patients who develop physical dependence on opioids can be easily tapered off.

FACT Successfully tapering chronic pain patients from opioids can be difficult—even for patients who are motivated to discontinue opioid use.³³

Myth Addiction is rare in patients receiving medically prescribed COT.

FACT Estimates vary. Between 4% and 26% of patients receiving COT have an opioid use disorder.⁹⁻¹² Among patients without an opioid use disorder, more than one in ten misuse opioids by: intentional over-sedation; concurrently using alcohol for pain relief; hoarding medications; increasing dose on their own; and borrowing opioids from friends.^{9,15}

Myth Addiction is the main risk to be concerned about when prescribing opioids.

FACT Opioids have significant risks besides addiction and misuse.^{18,19} These risks include respiratory depression and unintentional overdose;^{20,21} serious fractures from falls;^{22,23} hypogonadism and other endocrine effects that can cause a spectrum of adverse effects;²⁴ increased pain sensitivity,²⁵ sleep-disordered breathing,²⁶ chronic constipation and serious fecal impaction,^{27,28} and chronic dry mouth which can lead to tooth decay.²⁹

Myth Extended-release opioids are better than short-acting opioids for managing chronic pain.

FACT Extended-release opioids have not been proven to be safer or more effective than short-acting opioids for managing chronic pain.³⁰

Myth Prescribing high-dose opioid therapy (≥ 120 mg morphine equivalents/day) is supported by strong evidence that benefits outweigh risks.

FACT No randomized trials show long-term effectiveness of high opioid doses for chronic non-cancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.³² Higher doses come with increased risks for adverse events and side effects including overdose, fractures, hormonal changes, and increased pain sensitivity.¹⁸⁻²⁶

Myth Opioid overdoses only occur among drug abusers and patients who attempt suicide.

FACT Patients using prescription opioids are at risk of unintentional overdose and death.²⁰ This risk increases with dose and when opioids are combined with other CNS depressants like benzodiazepines and alcohol.²¹

Myth Dose escalation is the best response when patients experience decreased pain control.

FACT When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but it can increase risks.³²

Dos and don'ts for acute pain management

DO explain that opioids are for time limited use. With the first opioid prescription, set expectations that opioids should be discontinued when the pain problem is no longer acute.

DON'T stock your patients' medicine cabinets with unused opioids. Limit all initial and refill prescriptions for acute pain. A 30-day supply is often excessive—many patients only take a pill or two then leave the rest in their medicine cabinet. This increases the risk of diversion, which in turn increases the risk of addiction and fatal overdose in families and communities. For those patients who use the medicine daily for several weeks, physiologic dependence develops within days or weeks. Due to risks of accidental poisoning, it is important to store opioids in a medication lock box and flush unused opioids down a sink or toilet.

DON'T start long-term use of opioids by accident. Long-term opioid prescribing should only occur after careful patient evaluation, discussion of risks and realistic expectations of benefits, and clear explanation of rules for safe use. Routine authorization of refills may cause patients to expect the prescription to continue indefinitely.

DON'T prescribe extended-release opioids for acute pain or to opioid-naïve patients. Extended-release opioids are not appropriate for managing acute pain and should never be prescribed to an opioid-naïve patient.

Dos & Don'ts for chronic pain management

DON'T initiate chronic opioid therapy (COT) before considering safer alternatives such as primary disease management, cognitive-behavioral therapy (CBT), participating in pleasant and rewarding life activities, physical therapy, non-opioid analgesics and exercise.

DO screen patients for depression and other psychiatric disorders before initiating COT. Patients with depression and other mental health problems often present with pain problems. They may not know that mental health problems can contribute to chronic pain. These patients are at higher risk of opioid addiction. They may be better served by mental health treatment.

DO talk with patients about therapeutic goals, opioid risks, realistic benefits, and prescribing ground rules. Therapeutic goals should include increased activity and improved quality of life, not just pain relief. Patients should understand the full range of opioid risks and the limited benefits they can reasonably expect. The rules for safe and appropriate use of opioids need to be explicit, preferably documented in a written treatment agreement.

DO realize that patients are reluctant to disclose a history of substance abuse. A history of substance abuse indicates greater risk of opioid addiction, but getting an accurate picture of past and current drug use can be difficult. If a patient denies past or current substance abuse, recognize that they may be afraid to tell you the truth. Consult the medical record, a Prescription Drug Monitoring Database, and third parties as needed.

DO perform a thorough medical evaluation and a urine drug screen before initiating COT. Starting chronic opioid therapy should be an affirmative decision based on adequate assessment of risk, urine drug screening, and use of a treatment agreement. Because it can be difficult to know if a patient is seeking opioids for addiction or diversion purposes, COT should only be considered by a physician who has an ongoing relationship with the patient. The prescribing physician should be willing to continue working with the patient if problems arise.

DO explain to patients that discontinuing opioids may be difficult. Some patients find it difficult to taper off of opioids, particularly from higher dose regimens, even when they are eager to do so. Patients can experience increased pain, insomnia, or anxiety when tapering from opioids. These unpleasant withdrawal symptoms can last for several weeks. Do not abandon chronic pain patients after discontinuing opioids.

DO perform random urine drug screens on patients receiving COT. Urine drug screening helps identify patients using illicit drugs or not taking the medicine as prescribed.

DON'T continue COT with patients who show no progress toward treatment goals defined by increased function and reduced pain.

DON'T assume patients know how to use opioids safely. Opioids are powerful drugs that patients sometimes use in unsafe ways. Risks of unsafe use increase with prescribed dose and are greater for extended-release medications with long half-life. Patients often do not understand that it can be unsafe to take extended-release opioids “as-needed for pain.” Take time to talk with patients about how they are using opioids. Ask patients about their problems and concerns.¹⁷

DON'T assume patients use opioids as you intend. Many patients vary their dose and use combinations of other CNS depressant drugs or alcohol in ways that you may not know about. Patients may also sell their medications or share them with others. Opioid misuse often occurs among patients who do not have an opioid use disorder.^{9,15} Vigilance for unsafe use is essential.

DON'T start a treatment that you are not prepared to stop. Don't initiate COT without benchmarks for stopping, a procedure for tapering that you are willing and able to use, and an approach to managing physical and psychological withdrawal symptoms. If substance abuse is identified, taper opioids and make arrangements for substance abuse treatment.

DON'T assume patients are doing well with COT without careful evaluation. Careful and compassionate interviewing about opioid use and misuse, questions about your patients' problems and concerns,¹⁷ screening questionnaires, urine drug screening, and information from Prescription Drug Monitoring Databases often reveal problems with prescription opioids that would otherwise be missed.

DON'T abandon patients with a prescription drug problem. For patients who are misusing or addicted to prescription opioids, offer help or referral to someone who can treat substance abuse.

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